Confederation of Postgraduate Medical Education Councils

CPMEC SUBMISSION TO COAG HEALTH WORKING GROUP

Second Consultation Paper:
Proposal for a National Registration Scheme for Health Professionals and a National Accreditation Scheme for Health Education and Training

Introductory Comments

Following the consultations of 4 December 2006, CPMEC circulated the proposed models to member state postgraduate medical education councils (PMCs) for comment. This submission represents a consolidation of responses to the proposed registration and accreditation schemes.

As indicated in our earlier submission, CPMEC is supportive of government initiatives to facilitate workforce mobility, improve safety and quality, reduce bureaucracy, and simplify and improve the consistency of current arrangements. Indeed, national arrangements would be welcomed by medical trainees who are required to work in different states to meet their training requirements. Further, we acknowledge the intention of COAG to 'build on existing accreditation processes and expertise'. As mentioned in our initial submission, CPMEC is currently in the process of developing a national accreditation framework in the prevocational medical education and training domain. This will build on the national curriculum framework for junior doctors developed in 2006.

However, there are some concerns within PMCs that the proposed model is too centralized and the same or even better results could be achieved with an alternative model that strengthened the local committees who would undertake most of the operational work, and be supported by lean national co-ordinating bodies. Further, the proposed structure is seen by some as being complex comprising two boards, two advisory committees, nine discipline panels (with the probability of more in the future) and offices in each state and territory. This has the possibility of unnecessary duplicity of activity especially as the current proposals tend to set registration apart from accreditation.

If it is considered that the Australian Medical Council (AMC) is to be reconstituted as the medical professional panel, CPMEC would like to ensure that explicit recognition is given to the role of postgraduate medical education councils in prevocational medical education and training.

In relation to the eleven questions posed in the 2nd consultation paper, we would like to note the following specific points on some of the questions:

1. Composition of Registration Authority Board
A consideration to have the chair of the Health Professions Advisory Committee also sit on the Board of the HRA has been suggested as a means of ensuring that the views of the Professional Panels are directly articulated at the Board level.

There was additional concern that the model triplicated functions with the HRA, professional panels and local panels. Reporting through these levels could become very inefficient and result in considerable delays unless there was major delegation of tasks, which then made a top heavy structure unnecessary. To some degree it is recognised that this complexity is inevitable given the broad scope of the health profession.

From a whole-of-health profession perspective, it would be desirable to have some, if not all, of the other alternative practitioners brought under the aegis of the proposed system. However, it would be important to ensure that orthodox practitioners maintain a majority on all boards and committees (which would probably discourage the alternative practitioners from joining!).

4. Local Presence
One of the key challenges in this regard would be to have robust national frameworks to manage 'centre-periphery' tensions especially in the initial transition phases.

To a large degree, the local presence would depend on the size of the profession and on each panel's workload. Perhaps this should be left to each panel to decide. The possibility of state representation would need to be incorporated in the budgetary process.

6. Consumer Representation
CPMEC supports the proposed arrangements for consumer representation but wants to ensure that it is effectively done. In this regard, we support the need for these representatives to be provided with the necessary information and support so that they do not feel overwhelmed by the technical expertise of other members.

7. Appropriateness of State/Territory Offices
There is no mention of some of the current interactions of medical boards with other bodies such as postgraduate medical education councils. We consider that this is important in recognising the progression from provisional to full registration. In addition, the role of jurisdictional bodies that support health professionals needs to be acknowledged. The Victorian Doctor's Health Program is an illustration in this regard.

It is also noted that the proposal does not ask for comments on the bodies which hear more serious disciplinary matters that may result in suspension or cancellation of registration, which will be undertaken by 'state and territory based entities external to the HRA' (Health Registration Authority). The composition of these entities and of the panels which hear the disciplinary matters is very important. Under the current system for medicine these are initially heard by the jurisdictional medical boards. It would be a retrograde step if the expertise of these boards was lost or, if there was inadequate professional representation in the new 'entities' or disciplinary panels.

8. Fees Setting
It will be important that the mechanism used to calculate costs for each health profession is transparent.

In relation to accreditation, the issue of fees has not really been addressed and could be significantly higher if it is based on full cost recovery as proposed. Further in relation to accreditation, the fee setting process needs to account for local differences i.e. remote, rural, regional, outer metropolitan, and metropolitan. As noted previously, current accreditation processes operate on a lot of good will that may not be sustainable in the long term especially as the process starts crossing state and territory borders.

9. Proposed Composition of Accreditation Authority Board
CPMEC would prefer a greater level of health and education expertise in the Accreditation Board than currently proposed. As with registration, the chair of the Accreditation Advisory Committee should also sit on the Board. The Board membership may need to be expanded if other allied health and alternative practitioner disciplines join in.

There is no comment on the accreditation of training sites with the focus being on accrediting training courses. Accrediting of training sites and positions is a major domain of activity in medicine that is currently being performed by Colleges and postgraduate medical councils. It is a very important mechanism for maintaining the standard of postgraduate training and needs to be explicitly recognised in any new system.

10. Professional input on panels
We would like to reiterate our earlier concern that the medical professional panel includes the specific expertise of postgraduate medical education councils on prevocational medical training matters.

11. Clinical assessments of international medical graduates (IMGs)
Individual assessments should be the responsibility of the panels who should be given the mandate and resources to delegate to expert bodies as appropriate. There is a tension between getting appropriately trained people into the country in a timely and efficient manner and the perception that some professional bodies unreasonably delay accreditation to protect prestige and/or maintain high fees. The panels should have the responsibility to maintain standards. Obviously it will be important to have some rules and assessment processes which employers have to observe and fund.

The AMC is considerably advanced in developing comprehensive and robust instruments to assess IMGs and PMCs have been taking an increasing responsibility in this area. CPMEC would like to reiterate the need for resources to support ongoing training for IMGs who are allowed to work with restrictions and are shown to have knowledge and skills gaps when assessed. Any clinical component of IMG assessment will need to be in a clinical site, most probably at the place of employment. It is unclear who will do the assessment at this stage but this will have significant resource implications.

Prepared by CPMEC, 18th January 2007